Connecticut State Police

After Action Report

Newtown Shooting Incident
December 14, 2012



“Criticism may not be agreeable, but it is necessary. It fulfills the same function as pain in the human body. It calls attention to an unhealthy state of things.”

-Winston Churchill

“Transparency breeds self-correcting behaviors”

- Admiral Thad W. Allen (Ret.)
23rd Commandant of the U.S. Coast Guard

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1. Memoriam

The Connecticut State Police pays tribute to the 26 innocent lives that were taken on December 14, 2012 at the Sandy Hook Elementary School shooting. We pray that these names and their legacies are forever remembered.

Students:

Charlotte Bacon
Daniel Barden
Olivia Engel
Josephine Gay
Dylan Hockley
Catherine Hubbard
Madeleine Hsu
Chase Kowalski
Jesse Lewis
Ana Marquez-Greene
James Mattioli
Grace McDonnell
Emilie Parker
Jack Pinto
Noah Pozner
Caroline Previdi
Jessica Rekos
Avielle Richman
Benjamin Wheeler
Allison Wyatt

Faculty and Staff:

Rachel D'Avino
Dawn Hochsprung
Anne Marie Murphy
Lauren Rousseau
Mary Sherlach
Victoria Soto



2. INTRODUCTION

At approximately 9:35 a.m. on December 14, 2012, a lone gunman parked his vehicle in the fire lane in front of the Sandy Hook Elementary School, located at 12 Dickenson Drive in Newtown, CT. Armed with a semi-automatic rifle and two pistols, he shot out one of the front lobby windows and entered the school, bypassing the locked front doors. He was confronted by and he fired upon the school's principal, school psychologist and head teacher, all of whom had left a meeting upon hearing the sound of gunshots and broken glass. The principal and psychologist were killed in the front hallway and the head teacher was wounded. The gunman eventually walked down the front hallway and entered two first grade classrooms, firing upon and killing two teachers, a behavioral therapist, a teacher's aide, and 20 first graders. Nine first grade students from the two classrooms survived the shooting. At approximately 9:41 a.m. the gunman took his own life in classroom 10, where he was later found by first responders. The entire incident took approximately six minutes. Later, that day, it was also determined that the gunman had shot and killed his mother at their residence earlier that morning. The Connecticut State Police (CSP) were among the first responders. In coordination with the Newtown Police Department, the CSP took command of the scenes at the Sandy Hook Elementary School and the gunman's residence.

The Town of Newtown has its own organized police department, at the time consisting of 48 officers and support staff under the direct control of the Chief of Police. The Newtown Police Department provides primary law enforcement services to the residents of the town to include any calls for service at the local schools. The CSP Troop A - Southbury is located at 90 Lakeside Road in Southbury, approximately 6.4 miles to the north of Newtown, off of exit 14 on I-84. The State Police provide primary policing services to towns without established departments through either patrol functions from each of the 11 State Police Troops or through the Resident State Trooper Program. As a matter of protocol, the CSP provide available law enforcement response resources to towns that have their own established police department when requested to do so. On December 14, 2012, and in the weeks and months following the shooting, the State Police provided its resources to the town of Newtown.

The unprecedented nature of this incident posed numerous challenges to the CSP. The unique dynamics of this tragedy tasked the agency's resources and tested the capacity and capabilities of individuals and units alike. The purpose of this After Action Report (AAR) is both to inform and improve the agency's response capabilities and to provide the reader with a review of the many challenges faced by the State Police. Each person who contributed information to inform this process is dedicated to keeping the citizens they serve safe and to supporting other law enforcement agencies. The painstaking process of revealing personal and professional vulnerabilities as well as highlighting strengths is overshadowed by the necessity to be transparent and share valuable information with fellow law enforcement partners and the residents of Connecticut.

This AAR describes various activities of the Connecticut State Police in response to the incident, and conveys insights of the initial response, rescue, recovery, and investigative activities as seen through the lens of the Connecticut State Police response community. The report provides a holistic, comprehensive, and constructively critical review, incorporating the views of persons at various organizational levels within the Connecticut State Police. This incident produced a unique paradigm of response considerations and requirements. It was a major police and emergency response operation within the broader context of an active shooter attack that resulted in 28 deaths (including that of the shooter) and additional wounded.

The information in this AAR was compiled from various sources including personal observations, debriefing sessions, personal and group interviews, consults, and investigative reports. The information collected yielded many general lessons learned and specific recommendations. The information compiled for this AAR represents the views of many individuals, both within and outside the agency, at different times during the response producing legitimate, but often varying perspectives.

3. TERMS, ACRONYMS, AND CONNECTICUT STATE POLICE TABLE OF ORGANIZATION

Brief Description:

An after action review is a process used by an organization to capture the lessons learned from past successes and failures, with the goal of improving future performance. It is an opportunity for the organization to reflect on an activity or event so that they can do better the next time. AARs should be carried out with an open spirit and with no intent to blame. The AAR is a form of group reflection; participants review what was intended, what actually happened, why it happened, and what was learned.

In accordance with agency policy, an AAR may be conducted for any incident in which a commander considers it appropriate to evaluate and improve unit performance. The AAR is designed to review and analyze department tactical and administrative responses to an incident or event. The department must constantly evaluate the actions of its personnel to improve task performance. The AAR is designed to provide candid and constructive insights to better prepare the organization, and the broader law enforcement community, to appropriately respond to incidents in the future.

I. Terms

Issue - Brief summary to describe an action that was observed by a respondent. Issues are classified in sequential order under each annex as (I).

Discussion - Refers to the reflective observations of what transpired from the perspective of the response participants.

Recommendation - Provides potential solutions or next steps in response to an identified Issue. Recommendations are classified in sequential order under each annex as (R).

II. Acronym List

AAR	After Action Report
AGENCY	DESPP/CSP
A&O	CSP Administrative and Operations Manual, 5^{th} Edition
ATF	Bureau of Alcohol, Tobacco, Firearms and Explosives
CAD	Computer Aided Dispatch
CDMC	Central District Major Crime
CP	Command Post
CSP	Connecticut State Police
CTIC	Connecticut Intelligence Center
DESPP	Department of Emergency Services and Public Protection
EAP	Employee Assistance Program
EDMC	Eastern District Major Crime
EOC	Emergency Operations Center
ESU	Emergency Services Unit
FBI	Federal Bureau of Investigation
FLO	Family Liaison Officer
IDROP	Issue Discussion Recommendation Obstacle Proponent
JTTF	Joint Terrorism Task Force
LE	Law Enforcement
LEAS	Law Enforcement Administration System
PIO	Public Information Office/Public Information Officer
NESPAC	New England State Police Administrators Compact
RMS	Records Management System
SA	State's Attorney
SHES	Sandy Hook Elementary School
SPTU	State Police Tactical Unit
STOPS	State Troopers Offering Peer Support
USA	United States Attorney
WDMC	Western District Major Crime

III. Connecticut State Police Table of Organization

Senior Executive Level - Sworn member of the Connecticut State Police that is of the rank of Colonel or Lieutenant Colonel.

Executive Level - Sworn member of the Connecticut State Police that is the rank of Major.

Command Level - Sworn member of the Connecticut State Police that is the rank of Captain or Lieutenant.

Supervisory Level - Sworn member of the Connecticut State Police that is of the rank of Master Sergeant or Sergeant.

Trooper/Trooper First Class - Sworn member of the Connecticut State Police assigned to a unit or patrol function.

Detective - Sworn member of the Connecticut State Police assigned as an investigator to a major crime squad or other specialized investigative unit.

Dispatcher - Civilian member of the Connecticut State Police assigned to a Troop or communications center in a dispatch function.

Abbreviations

COL	-	Colonel
LTC	-	Lieutenant Colonel
MAJ	-	Major
CPT	-	Captain
LT	-	Lieutenant
MSGT	-	Master Sergeant
SGT	-	Sergeant
TFC	-	Trooper First Class
TPR	-	Trooper
DET	-	Detective
DISP	-	Dispatcher

4. ANNEXES

This AAR is organized into six (6) annexes:

Annex A – Initial Response includes insights and recommendations from the initial responding units from the Connecticut State Police.

Annex B – Tactical Operations describes the response of the Connecticut State Police Emergency Services Unit, to include the SPTU, Bomb, and K-9 Unit personnel.

Annex C – Criminal Investigation presents the activities of the three Connecticut State Police Major Crime Units.

Annex D – Command Post/Communications presents the activities of personnel assigned to primary and secondary command post operations throughout the initial response and subsequent period, including post-event activities. This Annex also includes the review of the role of the CSP Public Information Office.

Annex E - Support Services presents perspectives on activities categorized as a support function to agency personnel as well as in support of the victims' families.

Annex F - Survivors' and Victims' Families presents specific and general feedback on the Connecticut State Police response to this incident as viewed from the perspective of some of the family members of the victims and survivors who volunteered their insights for this report. It is noted that not all of the family member's viewpoints are documented in this report.

ANNEX A

ANNEX A - INITIAL RESPONSE

Introduction

Annex A attempts to capture some of the early deployment actions and subsequent self-assessments of the Connecticut State Police from varying perspectives and observations of first responding Troopers. Upon arrival on scene, Troopers entered the school with many unknown factors, including but not limited to the number of suspects, the weapons being used, the possibility of explosive devices or traps, the number and location of victims, the extent of victim's injuries, and the layout of the school. After linking up with Newtown police officers in the school, CSP first responders coordinated their resources in an attempt to locate any threats, treat the injured, and evacuate the school. As numerous law enforcement and emergency personnel arrived on scene, task delegation began to center on establishing and maintaining a perimeter as well as conducting a more systematic and coordinated search of the school.

Responsibilities

The responsibilities of first responding law enforcement personnel to any active shooter incident are to arrive safely on scene, make initial assessments, and neutralize active threats to the extent possible. Subsequent functions include coordinating available resources, providing aid to the injured, and preserving the crime scene.

At the time of this incident, Troop A - Southbury was commanded by a Lieutenant, assisted by a Master Sergeant as the Executive Officer. On December 14, 2012, the Troop A staffing consisted of 6 patrol Troopers, 2 Resident Troopers, 1 evidence officer, 1 desk Trooper, 2 patrol Sergeants, and 2 Resident Trooper Sergeants, in addition to the Lieutenant and Master Sergeant. In addition to Troop A personnel, the incident response engaged a large number of other personnel from other Troops and specialized units in the CSP, both on and off-duty, as well as people from other agencies from all levels of government and the private sector, and the response lasted for an extended period of time.

The following observations do not denote all of the activities associated with the initial first responders during the Newtown shooting incident, but rather notable observations that warrant further consideration. Personnel from the Connecticut State Police who initially responded to Sandy Hook Elementary noted the following:

Issue – Discussion - Recommendation

Issue
(A.I.1) Arriving safely at the scene.

Discussion
Despite the need to arrive at the scene as quickly as possible, and despite the stress of responding to an active shooter call, there were no reported incidents of responding Troopers having been involved in a motor vehicle crash while in transit. Troopers responding to the scene were able to do so safely and in a timely manner.

Recommendations
(A.R.1) The agency should continue to utilize current department policy, consistent with state statute, that dictates response protocols and emergency vehicle operation procedures.

(A.R.2) Supervisors should continue to reinforce the need for Troopers to arrive safely at any scene to avoid the redirection of resources from the primary call for service.

(A.R.3) The CSP Training Academy currently has a robust emergency driving program for recruit level training, and this type of training should continue.

(A.R.4) Advanced level driver training is now being conducted and consideration should be made to offer it regularly for field personnel.

Issue
(A.I.2) Protective Vests/Other Equipment

Discussion
Current department policy mandates that sworn personnel have their protective vests with them while working, however it does not mandate the wearing of protective vests. Some responding Troopers noted they did not have their vests on at the time of the call, but that it was stored in their vehicle. Although the time to retrieve and don the equipment in these cases was minimal, it was an added step in their response time. In one instance, it was reported that a first responder donned his vest while driving his vehicle to the scene. Additionally, most Troopers reportedly failed to respond into the building with their flashlights, which put them at a tactical disadvantage while searching interior portions of the school.

Recommendation
(A.R.5) If a Trooper is not wearing their protective vest, they should have a vest carrier readily accessible in the vehicle that can be easily and quickly slipped on. The vest carrier should be clearly marked and readily identifiable as POLICE. The

agency should consider purchasing tactical carriers allowing Troopers to carry extra rounds, medical equipment (tourniquet/quick clot), and a flashlight. Each Trooper should be equipped uniformly and in a clearly identifiable manner.

Issue

(A.I.3) Identification of Police Personnel

Discussion

Personnel were observed walking around the school and parking lot with long guns and handguns displayed, and were not sufficiently identifiable as police officers as opposed to a possible suspect. This could cause further panic among civilians, a "blue on blue" friendly fire situation, or a decrease in scene security. Current department policy addresses the issuance and apporopriate use of raid jackets[1].

Recommendations

(A.R.6) In addition to the issued raid jacket, the agency should consider purchasing an arm band clearly marked POLICE which can easily be carried by off duty personnel and made readily accesible.

(A.R.7) The department should sustain the current practice of requiring bi-annual personnel inspections which ensure that each Trooper in the agency has the required issued equipment.

Issue

(A.I.4) Parking of emergency vehicles

Discussion

The narrow entry road to the school became a log jam of vehicles and made ingress and egress up to the school for later-responding personnel difficult or impossible. Even after the active shooting had ceased, responding officers parked their vehicles in an obstructive fashion. Many of these first responders were CSP personnel, and many of the cruisers were locked, some with the engines running. The agency currently has a policy dictating that unattended department vehicles should be locked and the vehicle keys removed, and some newer vehicles have the capability of disabling the vehicle while it is still running.

Recommendations

(A.R.8) All department personnel should be trained in how to override the disabling mechanism in equipped vehicles so that they can operate them if needed.

[1] A&O 13.3.6- Wearing of raid jackets

(A.R.9) Reinforce the importance to all personnel of parking in a manner that does not restrict access to the scene, if at all possible.

(A.R.10) If the technology exists, consider the possibility of creating a "master key" that would permit entry and operation of all CSP vehicles to be carried by responding Troop supervisors.

Issue

(A.I.5) Off-duty use of assigned cruiser

Discussion

Many off duty personnel heard initial reports of the incident while in their cruiser and were able to immediately respond. For example, an off-duty Trooper had just dropped his child off at a nearby school when he was made aware of the incident. As there were early reports of a possible second gunman, the off duty Trooper took the initiative to enter the nearby school and coordinate with school administrators to place the school in lockdown while monitoring the incident at SHES. After several hours, it was deemed safe to release the lockdown and release the students to their parents. The presence of the off-duty Trooper at the other school provided a great deal of comfort to the staff during the incident and numerous parents and students related their gratitude.

Current department policy dictates the off duty use of vehicles describing the rationale and associated protocols.[2] The ready availability of off duty personnel allowed a faster and more robust response to the incident.

Recommendation

(A.R.11) Maintain the off-duty use of cruisers.

Issue

(A.I.6) Search and clear procedures

Discussion

A significant part of the initial law enforcement response to SHES involved the searching of the school for suspects and victims. The size of the school made this a difficult task, but the large number of personnel who self-deployed from multiple agencies made the task more difficult to accomplish efficiently.

After the initial rapid search for the gunman, most doors were locked. One of the challenges was getting access into the secured rooms. Teachers and students refused to open doors, even

[2] A&O 13.8.1- Off Duty use of Assigned Cruiser by Troopers

to law enforcement officers who attempted to show proof of identification, and LE was not aware of a "safe word" for the school system.

In some instances, teams would reportedly search a room and then move on, which led to later-arriving teams re-searching those rooms. Other teams assigned personnel at strategic locations to notify newly arriving personnel that a room had been previously cleared.

Despite the multiple agency response and no clear rank structure established at the outset, personnel worked exceptionally well together. LE remained in place until the entire interior was deemed secured and until a search was conducted by ESU. Coverage was maintained at each major intersection of hallways. LE had direct line of sight to each other and were able to ensure that no unauthorized personnel entered or contaminated the scene. When the ESU team arrived to conduct their search, a CSP commander informed them of what had been accomplished and advised them of the locations of interior perimeter personnel.

Efforts were made to utilize evacuation routes for students and teachers out of the school so that they did not have to pass victims in the hallways. Where this was not possible, students who had to pass in that hallway were directed to cover their eyes.

When formed up in search teams, it is a challenge to maintain muzzle discipline. There were several reported incidents of officers "flagging"[3] one another during search operations.

Recommendations

(A.R.12) All CSP personnel should continue to receive active shooter training at the recruit and in-service level.

(A.R.13) Law Enforcement statewide should be trained to utilize uniform search and clear procedures, as well as a universally accepted method of marking a room to indicate it has already been searched.

(A.R.14) Whenever feasible, when evacuating victims (especially children) from a scene, consider a route that does not unnecessarily expose them to graphic or disturbing sights and direct them to shield their eyes if it is unavoidable.

(A.R.15) LE personnel should ensure they maintain weapon muzzle discipline when conducting room clearing and search operations.

Issue

(A.I.7) Pre-planning for high profile locations

[3] Refers to the pointing of a weapons muzzle inadvertently at another.

Discussion

There was uncertainty by CSP personnel on the most direct route to get to the scene. As a result, numerous 911 calls were made by responding personnel requesting directions to SHES, which resulted in an additional burden to busy dispatch personnel, as well as otherwise unnecessary radio transmissions. The time spent by desk personnel and dispatchers providing directions could have been better utilized.

Recommendations

(A.R.16) Personnel should be familiar with the locations of high profile locations in their Troop area. These pre-identified locations should be documented and this information be made readily available to dispatch personnel who should also be familiar with the best route of travel from major highways.

(A.R.17) Each Troop should create a book to be kept in the dispatch area containing pertinent information (directions, school layout, etc.) for all the schools and other high profile locations in their Troop area. In the event of a major incident, the information will be readily available and can be disseminated to other Troops and given over the air in one broadcast. This material should also be made available in electronic formats for speedier access and dissemination.

(A.R.18) Consider using the NexGen “chat" feature to dessiminate information rapidly.

Issue

(A.I.8) Perimeter Control

Discussion

One Trooper reported that he was assigned traffic control at the direct entrance immediately upon his arrival at the scene, and was reportedly alone in the assignment with the exception of two volunteer firemen. As additional responding units, media, and family members began arriving, coordinating parking and staging and controlling and maintining the perimeter became increasingly difficult.

Recommendation

(A.R.19) Develop a Perimeter Coordination Team (PCT) of first responders NOT already part of a tactical response team. The PCT would be responsible for initial response duties such as setting a physical perimeter line, coordinating parking for responding emergency units, family members and dignataries, maintaining a crime scene log of responding personnel, creating and maintaining an immediate press area, and keeping a clear entrance and egress for the incident. Establish and train with protocols that provide a clear understanding of the overall mission and needs to successfully manage the scene for all responding personnel.

Issue

(A.I.9) Encounters with civilians

Discussion

Responding personnel initially detained multiple civilians, including a parent and a custodian, who were mistakenly identified as possible suspects. While these types of interactions are often unavoidable, they diverted resources from other tasks while the subjects were identified and cleared.

Recommendation

(A.R.20) Responding officers need to quickly determine the difference between a bystanding civilian and suspect and use their experience and training accordingly. Responding officers should be very mindful of the presence of civilians in high stress scenarios, and must be able to quickly analyze, identify, and handle these situations so as not to divert unnecessary resources from the actual threat.

Issue

(A.I.10) Interagency Response and Coordination

Discussion

Immediately upon arrival, CSP personnel entered the school through the main lobby, where they had been advised the shooting began, and made contact with several Newtown officers in the west wing (hallway) who were detaining the school custodian. The Newtown officers were clearly identifiable, making it easy to distinguish and mitigate a possible "blue on blue[4]" incident. As additional resources arrived, some Troopers were redirected to establish an exterior perimeter, while other teams were formed to conduct a systematic search of the school. The response teams reportedly utilized a diamond formation to conduct the search. Several personnel had rifles and shotguns in the formations.

The agency currently engages in a statewide active shooter response program that involves training personnel from various agencies.

Recommendation

(A.R.21) The agency should conduct frequent and realistic training on active shooter responses, and include local police agencies whenever possible.

Issue

(A.I.11) Command and Control

[4] "Blue on blue" refers to officers mistakenly perceiving other law enforcement personnel as a threat which could result in accidental fratricide.

Discussion

It reportedly took time at the outset to determine which agency was going to assume overall command and control of the incident. Although the investigative responsibility was established early through communication between the SA and WDMC, CSP Senior Executive level command staff was initially unsure of the agency role.

Recommendation

(A.R.22) Senior CSP Executive level commanders and local police executives need to establish clearly defined roles and responsibilities as soon as possible when responding to an incident of this magnitude in a location out of CSP jurisdiction. Doing so will help mitigate any potential confusion and assist the agency in quickly deploying the appropriate resources.

ANNEX B

ANNEX B- TACTICAL OPERATIONS

Introduction

The Connecticut State Police Emergency Services Unit is comprised of various specialized sub-units, including two tactical teams (east and west), the bomb squad, the dive team, the K9 unit, search and rescue, and aviation. The unit is comprised of full time members assigned to ESU as well as part-time/on call Troopers primarily assigned to other units within the State Police but respond to calls for service as needed.

Responsibilities

The ESU became engaged in operations shortly after the initial reports of an active shooter. ESU personnel were part of the initial response, and subsequently engaged in building clearing at the school and the suspect's residence. For approximately two weeks, various elements of ESU, in conjunction with FBI SWAT, were also engaged in providing a Presidential security detail and dignitary protection missions for victim families and high-profile visitors. They responded to threats that resulted in clearing schools and churches, provided tactical support at funerals and memorial services, provided explosive detection K9 sweeps at various locations, conducted protective sweeps of large quantities of donated goods and various packages from around the world, and assisted other investigators with specialized response capabilities.

The following observations do not denote all of the activities associated with Emergency Service Personnel during the Newtown shooting incident but rather notable observations that warrant further consideration. Personnel assigned to the Emergency Service Units noted the following:

Issue – Discussion - Recommendation

Issue

(B.I.1) Activation of Emergency Service Unit Personnel

Discussion

The West Tactical Team was activated immediately upon being notified of the incident. The tactical unit sniper teams were conducting training in Hartford and responded to SHES, located approximately 50 miles away. The East Tactical Team was activated a short time later and directed to stage at Troop A in Southbury as a reserve force in the event it became necessary to deploy elsewhere. Due to the large number of emergency response personnel deploying to the incident, it became very difficult to move resources to and from the scene. During post incident briefings, team leaders determined that future active shooter response protocols should include an "all call" response activation.

Recommendations

(B.R.1) Tactical unit commanders should consider an initial reactionary force to neutralize the primary threat as well as maintaining capabilities to handle multiple threat locations. Consider using other responding tactical units from the FBI, NESPAC, or local agencies as a reserve force, if available.

(B.R.2) Continue to establish, maintain, and foster positive professional relationships with other law enforcement tactical response units to include those from the NESPAC states. Incorporate inter-agency training that focuses on multi-tiered attacks at several locations.

(B.R.3) Ensure tactical unit response protocols and specific tactics can be universally applied in the event tactical units merge together in an integrated response.

Issue

(B.I.2) Radio Updates

Discussion

While traveling to SHES, the responding tactical team members who deployed from training in Hartford received continuous updates from the CSP Message Center. These continuous updates proved to be very helpful in the initial planning strategies.

Tactical team leaders utilized alternative radio channels to effectively communicate with each other prior to arrival on scene.

Recommendation

(B.R.4) Dispatch personnel should ensure continuous radio updates occur during critical incidents.

Issue

(B.I.3) Accessibility to and layout of SHES

Discussion

When officers conducted initial and subsequent searches of the school, they were unable to locate access keys. Additionally, neither floorplans nor schematics of the school were readily available for tactical team search units.

Recommendations

(B.R.5) Law enforcement agencies should coordinate with representatives of high profile locations and consider the creation and locating of an LE Resource Box.

(B.R.6) A LE Resource Box should contain the following minimum items:

a. appropriate set and number of keys (commensurate to the size of the building) which would accommodate a timely and thorough search.
b. schematics to the building
c. contact person familiar with the layout of the building

(B.R.7) Consider integrating the building schematics into a readily accessible computer file that can easily be shared with responding units. The E-files can be opened at the tactical or incident command post and coordinated communication between search teams would be able to confirm that all areas have been searched.

Issue

(B.I.4) Room Clearing and Marking

Discussion

Prior to conducting their search, the tactical team leaders directed all police personnel inside the school to exit any rooms and remain in the hallways. It was noted that attempts to mark the exterior doors were made using markers but the effectiveness of this marking system was questionable. The SPTU protocol for room clearing was based on extensive prior training and proved to be effective with the exception of the unsearched closets in the incident command post area which contained numerous LE command personnel.

Recommendation

(B.R.8) Law enforcement statewide should be trained to utilize uniform search and clear procedures, as well as a universally accepted method of marking a room to indicate it has already been searched. (*See* A.R.13)

Issue

(B.I.5) Tactical Team Operational Protocols

Discussion

The Tactical Team Unit reportedly deployed its search tactics consistent with their previous training, which all team members receive on a continual basis. Additionally, selected team members are provided further specialized training either individually or as a unit. Although the A&O Manual contains general tactical agency response protocols and tactical best practices have been developed and trained, there is no written document for SPTU personnel to reference with respect to these tactical protocols.

Recommendations

(B.R.9) In order to ensure future mission success and the continuity and development of best practices, it would be prudent for the tactical unit to create a Tactical Operations Manual that is updated regularly with documented lessons learned.

(B.R.10) The agency should continue to invest in appropriate equipment and continuous training to ensure the highest level of response capabilities.

Issue

(B.I.6) Command Post Location/Building Search Procedure

Discussion

The CP was initially established in the SHES main office, and the SPTU conducted a cursory sweep on the inaccurate assumption that the CP area was already fully searched. This resulted in the SPTU being called back to the school after having cleared the scene in order to conduct another search, which delayed the initiation of the scene processing. Additionally, another search of the school basement area was conducted by SPTU during the afternoon because it was not known to be accessible at the time of the first search.

Recommendations

(B.R.11) Prior to conducting a secondary and thorough search of a building, it should be cleared of all police personnel other than the search teams.

(B.R.12) Search team leaders should not make assumptions that specific areas have been cleared based simply on the presence of other police personnel. Open and candid communication between law enforcement personnel delineating specific areas of responsibility should be emphasized. Prior to relinquishing any crime scene to investigative personnel or other law enforcement resources, all areas within a building should be rendered safe, including attic and basement areas when applicable.

(B.R.13) Coordinate with school maintenance personnel or administrators to obtain building floorplans to ensure all areas are identified and appropriately searched.

Issue

(B.I.7) Deployment of Emergency Services Unit Personnel

Discussion

ESU was fully mobilized (SPTU and Bomb Squad) for approximately one week to address collateral duties including dignitary visits, building searches, protective sweeps, support for funerals, and use of K9 assets to screen donated goods, and continued to provide services as needed beyond that time.

When possible, ESU personnel wore softer style tactical clothing (polo style shirt with tactical trousers) and were encouraged to positively engage with community members.

Recommendations

(B.R.14) Tactical Unit commanders should anticipate redeployment of resources for collateral duties beyond the initial active shooter response. During high profile incidents, agencies must consider the resources needed to meet the various demands including dignitary protection details, funeral and memorial security, and screening of donated goods. Prior preparation and training in handling these scenarios are crucial to ultimate success.

(B.R.15) Consideration should be given to the image portrayed when tactical officers converge on a community that has been victimized by a mass casualty incident. When possible, reinforce positive community interaction with officers so that the citizens can begin to feel safe and secure.

Issue

(B.I.8) Tactical Integration with Other Teams for Sustained Activation

Discussion

The initial tactical response to SHES primarily involved components of the West Tactical Team supplemented with members of the East Team. The primary search responsibilities included the main components of the elementary school. Early in the incident, tactical members of the FBI arrived on scene to render assistance. The FBI conducted a search of the modular classroom area on the south side of the school while the CSP focused their search efforts in the main section.

In the week following the incident, CSP and FBI personnel collaborated to effectively sustain tactical operations. Multiple shifts were established and each team had designated areas of responsibility. This type of unit collaboration proved to be effective and reinforced a positive working relationship between the two agencies.

Recommendations

(B.R.16) It is important for tactical team commanders, team leaders and members to establish, maintain, and foster positive professional working relationships within the tactical operations community. As time and resources permit, tactical training should be integrated with other agencies.

(B.R.17) When integrating tactical teams for an operation, each team should report the results of their tasks to the tactical scene commander to prevent potential confusion.

Issue

(B.I.9) Self-Deployment

Discussion

Self-deployment of personnel presented a significant challenge. Numerous LE officers from various federal, state, and local agencies converged on SHES and the immediate area to provide assistance. The magnitude of response became problematic for accountability purposes and created further problems accessing the school as all roads became congested.

Recommendation

(B.R.18) Commanders must anticipate a large number of responses of LE officers and other first responders converging on the scene at a mass casualty event. It is critical to include staging as part of long term planning for disaster response at high profile locations, including primary and secondary parking plans with personnel and equipment (such as cones, barriers, and signage) dedicated to the task as early as possible.

Issue

(B.I.10) Scene Security

Discussion

During the early stages of the response, a perimeter was established for the safety of both LE and civilians and to maintain the integrity of the crime scene. Despite the perimeter, reporters and other non LE personnel did enter the school grounds. These types of preventable and unnecessary security breaches distract resources from their primary duties.

Recommendations

(B.R.19) Establish inner and outer perimeters as soon as possible and maintain strict access to and from the scene. Consider using crime scene tape, signage or loud speakers to clearly identify perimeters where possible to provide notice to those who might knowingly or unknowingly breach them.

(B.R.20) Self-deployed personnel should be assigned specific tasks upon arrival, such as securing the outer perimeter areas.

ANNEX C

ANNEX C - CRIMINAL INVESTIGATION

Introduction

Major Crime Unit detectives are assigned to districts and Troops to manage complex crime scenes, to process evidence and crime scenes, and to conduct extensive follow-up investigations. All major criminal investigations in a district are the responsibility of the Major Crime Unit commander.

Each district is assigned a Major Crime van with sufficient personnel and equipment to process crime scenes and evidence in complex circumstances beyond the capacity of the Troop or local police jurisdiction.

While WDMC was the lead investigative unit, the investigation was a joint effort by numerous local, state, and federal agencies, including the Danbury State's Attorney's Office, the US Attorney's Office, FBI, US Marshals, ATF, Newtown PD, Fairfield PD, and the Office of the Chief Medical Examiner (OCME).

In order to clearly delineate the responsibilities for the three CSP units, specific assignments were tasked to each as follows:

- WDMC: investigation of the shooting incident at SHES.
- WDMC Van: documentation and processing of the interior of SHES.
- CDMC: documentation and processing of the exterior of SHES, assistance to the OCME with autopsies
- EDMC: investigation of the homicide at the suspect's residence in Newtown, including documentation and processing of the home.

Responsibilities

Western District Major Crime

Soon after they became aware of the active shooter incident at SHES, WDMC personnel were dispatched via phone calls and the Everbridge[5] system with several tasks including 1) responding to the school to assist in saving lives and the evacuation efforts; 2) responding to area hospitals to account for victims, gather information, secure evidence, and work with the hospitals to ensure their safety; 3) staging, first at the Newtown Police Department and then at the Newtown Emergency Operation Center, to establish an investigative command post; and 4) to gather supplies and be available to respond as needed.

En route to the scene, the WDMC commander and a supervisor engaged in conversations with the Danbury State's Attorney Office, as the SA determines which agency will investigate a particular incident. The Danbury State's Attorney Office requested that WDMC conduct the criminal investigation. Subsequently, the WDMC commander requested additional assistance and resources from both CDMC and EDMC.

[5] Department-wide automated notification network.

An investigative command post was established at the Newtown Emergency Operation Center (EOC) and the WDMC van functioned as the crime scene command post at the school.

Central District Major Crime

The primary assignments of CDMC Van personnel were to process the exterior of the school, and to attend and report on the autopsies of the deceased conducted by the OCME. Secondarily, they provided assistance to EDMC at the residence of the accused. The remainder of CDMC personnel were assigned to the investigative command post at the Newtown EOC, where the investigative resources of all involved agencies coordinated their activities.

Eastern District Major Crime

The primary assignment of EDMC was investigation of the homicide at the suspect's residence including documentation and processing of the home and documentation of the autopsy of the victim. EDMC subsequently assumed statewide responsibilities for all other requests for major crime investigations.

The following observations do not denote all of the activities associated with the three Major Crime units during the Newtown shooting incident, but rather notable observations by unit personnel that warrant further consideration:

Issue – Discussion - Recommendation

Issue
(C.I.1) Crime Scene Security and Integrity

Discussion
At the outset, LE personnel from multiple agencies had access to the grounds due to the nature of the incident. Once the threat had been neutralized and the situation stabilized, access to the immediate scene was not strictly limited to Major Crime personnel with responsibilities in those areas. Other individuals, from uninvolved CSP command staff to members of outside agencies to dignitaries, were allowed into the school at one time or another over the next several days, disrupting the processing of the scene by detectives, potentially risking scene integrity, and unnecessarily exposing personnel to the disturbing scene.

Though there was a security perimeter set up around the school, only the front entrance was taped off to prevent entry. Other areas of the scene, from the main roadway up to the school parking lot and specific areas within the school, could have been better marked to indicate what level of access was appropriate.

Early on, a CP was set up inside the main office of the school despite the presence of an investigative CP already established at another location. This became problematic for numerous reasons, including:

- Unnecessary personnel (LE and civilian) inside the school lobby area after the scene was rendered clear. Relevant evidence was stepped on, including bullet casings and glass shards, which had yet to be processed and properly documented.

- While using the CP in the main office, phone lines were disconnected, copy machines were used, and office binders were removed prior to the room being processed and documented.

- The accuracy of the Crime Scene Log was difficult to maintain because of the location of the CP inside the lobby area.

- Each time an escorted visit into the crime scene took place, the investigators had to stop what they were doing, which caused difficulties from both efficiency and mental health perspectives.

Another reported issue was the separation between the investigative CP at the Newtown EOC and the main CP located at the Firehouse. Communication between agency personnel was hindered by being disparately located.

Recommendations

(C.R.1) Access to the crime scene should be strictly limited to authorized personnel, specifically major crime personnel. The investigating unit should maintain control and integrity of the scene, regardless of rank, and Troopers should be assigned to guard the perimeter. If it is necessary for individuals not directly involved in the investigation to view the crime scene, consider the utilization of photographs or video recording.

(C.R.2) In the event an escort through the scene is approved, it should be conducted after scene processing has been completed, if at all possible. Once completed, the LE officer conducting the escort should document its actions in a formal report.

(C.R.3) Establish two layers of perimeter around a crime scene, which could be distinguished by the color of the crime scene tape. An outer perimeter of one color tape could indicate the boundary for purposes of the public, with only LE and other authorized personnel having access. Within this ring would be an appropriate location for the the crime van. An inner perimeter, marked with a clearly different color tape, could delineate the crime scene, to which only scene processing personnel would have access. Enforcing a second perimeter would significantly limit unnecessary personnel from entering and exiting particularly

sensitive crime scenes while allowing all personnel to appropriately complete their assigned tasks.

(C.R.4) Establish clear department protocols regarding the location of command posts.

(C.R.5) Improve communication practices between tiers of command. It is an inherent communication challenge for the lower tier of a paramilitary structured organization to communicate upward especially when dealing with controversial issue, but open upward communication should be encouraged.

(C.R.6) Training for all personnel on the issue of crime scene security and the detriments of unauthorized or unnecessary access would be beneficial.

Issue

(C.I.2) Crime Scene Processing **-** Initial Scene

Discussion

During the early stages of command and control, there were unclear lines of initial roles and responsibilities. At times, commanders unfamiliar with the capabilities of specific units had a tendency to micro-manage, and there was a propensity to want to speed up certain tasks in order to identify victims faster.

Recommendation

(CR.7) Task delegation to personnel processing a scene should be handled by the Major Crime commander and supervisors. Orders or direction received from others in the chain of command should be referred to the Major Crime commander for reconciliation.

Issue

(C.I.3) Interior Scene Processing

Discussion

Particular challenges were raised for scene processing personnel by the high number of victims and the manner of death. Additionally, investigators identified the need to handle each item of evidence with particular care, not only for its evidentiary value, but out of respect for the victim and their families.

Recommendations

(C.R.8) Pay specific attention to documenting what may change in appearance or position upon further processing, as well as areas that will need to be used or accessed, such as bathrooms, office, phones, copy machines, etc. Process a path of entry to the victims early so that they may be processed first and identified quickly. The path of entry should be the path that creates the least amount of intrusion on the scene.

(C.R.9) Plan for processing victims as expeditiously as possible to obtain positive identification and evidence, in close coordination with the OCME. Request that the OCME obtain DNA samples from each victim.

(C.R.10) Plan for processing clothing of each victim, including access to an area large enough to dry clothing without cross contamination and secure enough for evidentiary purposes.

(C.R.11) Plan in advance for the return to family members of the victims' personal effects, and do not assume that any item is insignificant. This may include the need to decontaminate, launder or otherwise clean items prior to returning them.

Issue

(C.I.4) Essential Training and Tools for Mass Casualty/Active Shooter Scene Processing

Discussion

An event the magnitude of the Newtown incident required numerous agency resources to include investigators with specialized training and appropriate crime scene processing resources and equipment. Although Major Crime units had many items available, outside resources were needed for others.

Recommendations

(C.R.12) Major Crime units should ensure that multiple detectives in each district have received advanced, specialized training in areas such as crime scene processing, forensic digital photography, crime scene videography and mapping, evidence identification, processing and packaging, blood spatter pattern analysis, and shooting reconstruction.

(C.R.13) Major Crime units should ensure that they have access to the necessary standard and specialized equipment, including large quantities of packaging material (ex. paper, paper bags, banker boxes) and personal protection equipment (ex. gloves, booties, Tyvek suits), large scale mapping equipment, shooting reconstruction equipment (ex. tripods, laser tools with measuring devices), and items necessary for biohazard disposal. Other items that were utilized and found to be useful were

a large, ventilated tent for evidence processing with protection from weather and view, as well as portable toilets and portable water stations.

Issue

(C.I.5) Temporary Morgue

Discussion

Initially the OCME wanted to transport the deceased victims to its office in Farmington and do all investigative work at that location, however for practical reasons and in an effort to expedite identifications, a Deployable Rapid Assembly Shelter (DRASH) was obtained from an out of state entity and was utilized as a temporary morgue, including running water and heat. The DRASH was later used as a drying room for victim clothing prior to packaging for evidence.

Recommendation

(C.R.14) Establish protocols and training to facilitate the efficient and effective use of resources from other agencies.

Issue

(C.I.6) Major Crime Call-Out Procedure

Discussion

Personnel activation for deployment of on-duty personnel to SHES was made via routine communications channels. The Everbridge system was effectively utilized to mobilize off duty members of the Major Crime units.

Recommendation

(C.R.15) Maintain the use of the Everbridge call out system, and continue regular testing with the practice of the T-1[6].

Issue

(C.I.7) Inter Agency Collaboration

Discussion

Early in the response it was apparent that numerous investigative resources, federal, state and local, would be required at multiple locations. Once on scene at the school, the WDMC commanding officer identified leaders from other agencies, including Newtown PD, ATF, and FBI, and kept them together during the initial hours to facilitate communications until command posts were established. After the first week and after the CPs were broken down,

[6] A T-1 is the regularly-conducted test of the call out procedure for CSP personnel to ensure all Troopers are available within the designated response time.

resources and support initially offered were not as readily available. It took several meetings and phone calls to re-establish effective interagency communication..

The Newtown EOC was set up as the investigative CP. Communication between the investigative teams was good, however communication between the EOC and the incident CP at the firehouse was not as effective, in part because clearly identified command roles were not disseminated amongst personnel.

Briefings provided to the victims' families, survivor families, school staff, and Newtown PD were both factual and helpful, serving to clear up rumors and misinformation and provide direct access to accurate information.

Large-scale interagency collaboration, as well as the scope of the incident, led to deviations from standard Major Crime practice, and deviations between the practices of the three Major Crime districts became apparent. It also created difficulties with respect to report writing and documentation.

Information sharing between agencies, in particular between the FBI and CSP, was complicated in some instances due to different state and federal rules. While the issues were amicably resolved, they resulted in duplication of efforts and time spent that could have been better utilized. Differences in how the agencies conduct and document investigations were also observed that resulted in inefficiencies later.

Recommendations

(C.R.16) Personal points of contact and professional working relationships with leaders and members of other agencies should be established and maintained long before a critical incident takes place. Readily accessible contact numbers should be kept.

(C.R.17) Clearly defined roles and responsibilities should be established in order to accomplish the mission. Despite the magnitude of the incident and the number of agencies involved, the fundamentals of crime scene processing need to be maintained. Task delegation should be discussed among unit commanders and supervisors before arbitrary assignments are made.

(C.R.18) Accurate and timely information dissemination is critical to prevent rumors and to keep all affected personnel informed.

(C.R.19) Joint training between Major Crime units from different districts would be beneficial, and would help identify inconsistent practices that could be remedied.

(C.R.20) Consider assigning CSP personnel to work with members of other agencies to facilitate uniform documentation in CSP records of investigative activity. CSP personnel can document joint investigative efforts without having to rely on reports from other agencies.

Issue
(C.I.8) FBI Liasion/Joint Terrorism Task Force

Discussion
A decision was made to not have the JTTF supervisor assist with the investigation. A JTTF supervisor would have been an invaluable resource at the EOC and as the investigation continued.

Recommendation
(C.R.21) Inclusion of a JTTF supervisor should be considered as a resource to be involved in similar joint investigations.

Issue
(C.I.9) Briefings

Discussion
Briefings were conducted at least daily, and often more frequently, at both CPs, however there was no daily joint briefing with representatives from both CPs.

More sharing of information by both sides of the investigation (crime scene processing and criminal investigation) would have been beneficial.

Recommendation
(C.R.22) The daily briefings were useful and effective, but expanding them to ensure that all components of an investigation are included would be more beneficial. Colocation of CPs when possible would facilitate this type of information sharing.

Issue
(C.I.10) Report Writing

Discussion
Written reports relating to this incident were completed by many CSP personnel from across the state. Many reports and forms were submitted late, lacked sufficient documentation, or included grammatical and spelling errors. Many times, these reports were approved by supervisors without being adequately corrected.

The large number of individuals submitting reports resulted in confusing and sometimes inconsistent documentation of things like reference points, sides of the building, directionality of the school, etc.

Lead sheets were utilized to efficiently organize and track investigative leads and the resulting investigative efforts.

There was a separate team responsible for drafting search warrants, which some determined to be inefficient.

Recommendations

(C.R.23) Reports must be completed in a timely manner, and should be written clearly and concisely. Report completion prior to the end of the shift is preferred, but must be balanced with the physical and mental well-being of the report writer and other practical realities.

(C.R.24) Supervisors should reinforce the importance of accurate and timely report writing and take appropriate remedial action with respect to reports that do not meet standard. Supervisors should be held accountable for ensuring the timely submission of accurate, well-written reports.

(C.R.25) Ensure record management software is being utilized as required by agency policy.

(C.R.26) Train personnel on the importance of consistency in documentation, and issue basic maps with standardized orientation to investigators to use as a reference during their interviews.

(C.R.27) Provide additional opportunities for training in report writing, either voluntarily or as required to remediate deficiencies, to personnel who want or need it.

(C.R.28) Encourage the continued use of lead sheets by Major Crime units in large-scale investigations and ensure that all CSP supervisors are trained and familiar with their use.

(C.R.29) Warrants should be drafted by the unit processing the scene to ensure that all items to be searched for are covered in the warrant.

Issue

(C.I.11) Training

Discussion

Inconsistencies were noted within the agency with respect to investigative techniques and unit practices. While in part these may be attributed to the unique requirements of the various Judicial Districts, others were simply differences in the operations of the various units developed over time.

Recommendation

(C.R.30) The CSP should host Basic, Intermediate, and Advanced Crime Scene Investigation schools taught by subject matter experts from within the agency, augmented by nationally recognized experts in the field. In-house instructors would be more familiar with CSP practices, policies, and procedures. Training should be conducted on a regular basis, using internal agency resources to minimize cost.

Issue

(C.I.12) Back Up Coverage

Discussion

EDMC was able to provide a second squad to cover the state while the other Major Crime personnel were dedicated to the investigation at SHES. EDMC utilized an old crime van and outfitted it with much of the same equipment on the primary van.

Recommendation

(C.R.31) Explore the feasibility of outfitting a backup crime scene van in each district.

ANNEX D

ANNEX D- COMMAND POST/ PUBLIC INFORMATION

Introduction

During the initial stages of the incident, there was a large influx of emergency personnel converging on the scene, and it was identified very early that command post operations needed to be established quickly. On scene executive level commanders from Western District (WD), Central District (CD) and the Bureau of Criminal Investigations (BCI) delineated areas of responsibility among themselves to include the three main areas of command and control:

- *Immediate Crime Scene (Western District CO)* - Included all aspects associated with the effective processing of the SHES to include investigation, collection of evidence and victim identification.

- *Other Operations (Central District CO)* - Included oversight of all other operations to include, securing the suspect's home, other search operations, traffic control, and all other immediate law enforcement operations underway.

- *Command Post Operations (BCI CO)* - Included oversight of a) establishing an incident command post at the firehouse on Dickenson Drive, b) obtaining materials necessary to identify the victims, c) creation and implementation of a Family Liaison Program, d) coordinating needs of the victim's families, e) liaising with local and federal law enforcement and other non-governmental agencies offering aid and assistance and f) coordinating media release through the Public Information Office.

There were several command posts established:

- The *Incident Command Post* was established at the fire house on Dickenson Drive.

- The *Investigative Command Post* was established at the EOC located at the former Fairfield Hills Hospital, 3 Primrose Street, Newtown, CT.

- The *Crime Scene Processing Command Post* was established at SHES.

This annex will discuss the aforementioned observations by personnel who were assigned to the various command post locations with their recommendations that identify sustainable practices as well as noted challenges and areas for improvement.

Issue – Discussion - Recommendation

Issue

(D.I.1) Hot Line Operators

Discussion

Early on in this investigation, several detectives were assigned to answer the telephones at the Investigative Command Post, where numerous tips were received. Due to their high level of competence and knowledge of the investigation, the assigned detectives were able to redirect, follow-up, and/or exclude these tips in a timely and efficient manner. Lessons learned from previous major crime investigations have taught us that the detectives assigned to manning the Hot Line are critical positions.

Recommendation

(D.R.1) Consider adopting a hot line a standard operating procedure for large-scale incidents, and include in Command Post Training.

Issue

(D.I.2) IT issues at Command Posts

Discussion

An immediate issue was the lack of technology and IT resources. Detectives at the investigative CP had to use the town of Newtown's computers at the EOC. The lack of Wi-Fi capability was an issue in that there was limited/no internet connectivity. Laptops assigned to Major Crime detectives were minimally equipped, older models without air cards to connect to the internet, hampering investigative functions.

Recommendations

(D.R.2) Modernize agency laptops and purchase additional hardware for the Mobile Command Posts.

(D.R.3) Utilize agency IT personnel at CP locations as soon as possible to address IT issues.

Issue

(D.I.3) Mobile Command Post Vehicle

Discussion

The Mobile Command Post Vehicle (MCPV) arrived expeditiously the first day, but only provided phone and radio support. The CAD system and ability to use laptop computers in the vehicle was not established until day three. There was no way to send, receive, scan, and print documents, basic office supplies were minimal, and there was no access to the ATLAS scheduling system from the MCPV.

There are a limited number of personnel trained to activate the equipment on the MCPV, and no policy directing notification of personnel needed to activate MCPV equipment.

It was learned that radio division personnel are not able to activate the CAD system within the MCPV, nor could they initiate connectivity for the department laptops. This needed to be done by a member of the CAD/RMS unit.

Cell phone capabilities were very limited at the CP, and there was an inability to text on department phones. Very few personnel had access to a tablet or laptop and information had to be driven to locations in lieu of easy access to email.

Recommendations

(D.R.4) CAD/RMS personnel should be activated whenever the MCPV is called into service.

(D.R.5) The MCPV should be equipped with a scanner and basic office supplies. Regularly evaluate MCPV equipment needs and functionality, including after each incident in which it is utilized.

(D.R.6) Department members who are assigned cell phones should have the ability to utilize text messaging, and command level personnel should have access to internet-accessible tablets or laptops. Since February 2015, all command level personnel have been issued an iPhone and have the ability to text message.

Issue

(D.I.4) Command Post Communications

Discussion

In the early stages of the incident, there was insufficient communication between personnel at the scene and CP personnel or personnel assigned to secure the main access road regarding what resources were needed immediately and what resources needed to be prevented from entering. Once the scene became more stable, emergency response personnel continued to flood the school parking lot resulting in too many people entering the crime scene, which had not yet been secured or swept for secondary hazards.

Personnel working in the CP also reported that it was difficult and time consuming to locate and communicate with key agency members who were at other locations, and it would have been more effective to staff the CP with key agency decision makers from the outset.

There was a delay in establishing a staging area for responding personnel and failure of responding personnel to remain in the area of the CP to receive assignments as the needs arose. Once the active shooting ceased, resources arriving on the scene were not immediately directed to a staging location to wait which resulted in some personnel improperly self-directing their activities.

Recommendations

(D.R.7) Command staff personnel on scene need to immediately assess the scene, direct personnel accordingly, and ensure communication is maintained between scene personnel and staging area personnel.

(D.R.8) Provide regular training for all personnel, including command staff and supervisors, in reference to managing critical incidents.

(D.R.9) Encourage the presence of key leadership at the CP as soon and as consistently as possible.

Issue

(D.I.5) Traffic Control and Staffing

Discussion

In the days following the incident, numerous traffic and security posts were required to be manned on 12 hour shifts. The process for filling these posts was inefficient and not uniform. For example, some Troops identified volunteers, some ordered personnel in, and some posts were filled by the Special Duty Unit. Assistance offered by some agencies was turned away, when it could have been beneficial. Trooper Trainees were not utilized to maximize coverage at the scene.

On the night of the Presidential visit and vigil, the planned travel routes did not sufficiently account for the overflow of traffic caused by the influx of the public and media, resulting in a significant back up on I-84 and eventually all roads off exit 11 into Sandy Hook and requiring the assignment of additional Troopers for traffic control.

Recommendations

(D.R.10) Evaluate the most efficient manner for staffing, including what hours are most conducive to the scheduled work hours of Troops throughout the state, and prepare a staffing plan that can be referenced during critical incidents.

(D.R.11) Utilize the Everbridge system to uniformly notify agency personnel of additional staffing needs.

(D.R.12) Where feasible and available, consider utilization of other agency resources, such as Trooper Trainees and auxiliary Troopers.

(D.R.13) During event planning, be mindful of alternate routes becoming congested and redirect resources accoringly to ensure a coordinated traffic incident mangement response. Coordination between CSP Troops, the Traffic Services Unit and DOT is critical.

Issue

(D.I.6) EOC/CP Interaction

Discussion

In addition to the CSP CPs, the Newtown and State EOCs were activated, leading to confusion as to responsibilities for different tasks and the duplication of efforts in regard to some outside requests.

Recommendation

(D.R.14) Continue to train personnel in the methods of incident management, including tabletop exercises, and utilize the Unified Command Post strategies described in NIMS[7] to ensure a clear delineation of responsibilities and to facilitate communication among the different branches. Consider developing in-house personnel to conduct this training on a regular basis.

Issue

(D.I.7) Designate an area for families of victims

Discussion

The incident CP at the firehouse was not configured to allow for a separate area for the parents of unaccounted for children apart from parents reuniting with their children. Although there were indications that the unaccounted for children were deceased, Troopers were not at liberty to disclose that information. The process of positively identifying which children were deceased was very difficult to manage and should be considered when formulating future action plans.

Recommendation

[7] National Incident Management System

(D.R.15) Ensure the CP designates a secure location where families can wait, and consider having multiple locations separate from sight and sound for families of deceased and surviving victims. Assign an individual to answer questions and assist families in a transparent manner to help mitigate confusion.

Issue

(D.I.8) Secondary command post

Discussion

Since the incident CP at the firehouse was also a meeting place for families, locating the investigatory CP off site at the EOC proved to be critically important. It was helpful to have the investigatory CP in a location with minimal distractions. The EOC maintained its continuous investigative efforts because there were minimal distractions. The EOC was manned by Newtown patrolmen keeping the media at a distance. Rank and file did not interfere, allowing the investigators to complete their tasks.

Recommendation

(D.R.16) Consideration should be given for using a secondary, investigatory CP separate from the incident CP.

Issue

(D.I.9) Disseminating False Information

Discussion

An event of this magnitude causes stress and trauma on many levels for the individuals involved with the incident, and that is heightened when incorrect or inflammatory information is disseminated. Although the CSP will not be able to control individuals outside of their own organization, they should appropriately deal with those on the inside.

Recommendation

(D.R.17) Enforce policy within the CSP regarding the unauthorized dissemination of information.

Issue

(D.I.10) Equipment issues

Discussion

CSP portable radios had limited effectiveness inside the school. For example, in one instance a Trooper had to stand outside the building to transmit information that was being relayed to

him from inside the building. Additionally, the timestamps on some CSP mobile video recorders were found to be innaccurate.

Recommendation

(D.R.18) A long term solution should be found to remedy the radio system that is not reliable in certain locations, and MVR internal clocks should be checked to ensure accurancy.

Issue

(D.I.11) Release of investigative information

Discussion

In an effort to keep the victim's families informed, investigative information was provided to the families before the completion of the investigation and the information was subsequently released to the media.

Recommendation

(D.R.19) Do not release sensitive case information until the investigation is completed. The importance of keeping the involved parties informed must be weighed against the risk of information being leaked and the associated potential harm to investigative efforts.

Issue

(D.I.12) Death notifications

Discussion

Any delay in official notification increases anxiety to the families and the emergency response personnel on scene.

Recommendations

(D.R.20) Appropriate and respectful death notifications should be made as soon as possible and made by someone with training and experience in this area.

(D.R.21) Continue to conduct training on death notification protocols. Any CSP associated personnel such as chaplains and clergy should receive appropriate training in death notification and mass casualty situations.

Issue
(D.I.13) Virtual Command Post

Discussion
The Virtual Command Post (VCP) is a CTIC resource with the ability to capture all information on an incident and provide it in real time to involved commanders through a remote software messaging board. Access is granted by CTIC and the VCP can connect CPs in different locations to streamline information flow and decision making during critical incidents.

The VCP was established by CTIC within minutes of the initial 911 calls, but was not immediately utilized by the CPs. This was a very valuable resource and provided real-time information sharing for all calls and intelligence generated by the incident. These important notes and times were captured and were available to the various CPs if they had made liaison with CTIC.

Recommendation
(D.R.22) Ensure that all agency commanders are aware of this resource and that direct liaison is established with all CPs as soon as possible during a critical incident. This would provide all commanders with a more complete picture of the incident no matter their location, aiding in rapid decision making and dissemination of information.

Issue
(D.I.14) Self- Deployment of Emergency Response Personnel

Discussion
The voluntary response and self-deployment by police and volunteers became difficult to manage and maintain accountability. The early management of these resources became overwhelming particularly since they were co-located with the CP at the firehouse.

Technology exists so as to be able to manage personnel coming to and from a scene. The use of bar code readers or swipe cards would assist in keeping accountability of personnel at the scene and their respective assignments.

Recommendation
(D.R.23) Critical incident and mass casualty response training should incorporate the issues and challenges associated with self- deployment to the scene, and the agency should consider obtaining available technology for scene personnel management.

Issue
(D.I.15) STOPS/EAP CP

Discussion
STOPS/EAP was co-located at the incident CP, which allowed for immediate access to personnel, but provided a lower level of privacy than would have been ideal.

Recommendation
(D.R.24) When feasible, consider a separate but accessible location for STOPS/EAP from the CP.

Issue
(D.I.16) PIO Collaboration

Discussion
CSP PIO requested and received a Newtown police officer to assist in the selection of staging area and the management of local media issues. This was crucial as the CSP PIO was not familiar with the community and had limited knowledge as to where a media staging area could be set up or where necessary equipment could be obtained. The support of the local police partners was vital to the overall success, and setting this system up early limited the dissemination of misinformation.

Recommendation
(D.R.25) It is important for command staff from multiple agencies to set up a single PIO contact for the incident to ensure that communications are consistent and coordinated.

Issue
(D.I.17) PIO - Media Relations

Discussion
As time passed, the number of media increased dramatically, creating the challenge of re-briefing new media arriving on scene. It was critical to gather all media to a central staging area for all press briefings. Additionally, holding a question and answer session after each briefing enabled PIO to manage rumors as they were surfacing.

Recommendation
(D.R.26) PIO should remain neutral and ensure media information is released in a manner that is timely and that provides equal opportunity for dissemination.

Issue

(D.I.18) PIO- Media Briefings

Discussion

Advanced scheduling of press briefings encouraged media to remain in the staging area, as there were no second briefings if one was missed. PIO provided these updates to the press approximately every 90 minutes, frequently enough to ensure that they remained the primary source of information about the incident. It was the goal of PIO to strive for and achieve the factual and timely distribution of accurate information.

Recommendation

(D.R.27) Hold frequent and regular press briefings in order to provide timely and accurate information to the press and the public.

Issue

(D.I.19) PIO - Command Post

Discussion

There was a need for a PIO office area within the CP equipped with a telephone, fax, computers, copy machine, and other essential office equipment. Ideally it would be better to have a private PIO office, if possible.

Recommendation

(D.R.28) PIO staff should consider compiling a quick-response kit containing the necessary materials to set up a portable PIO, including basic office supplies, forms, press contact information and distribution lists, business cards and cell phone chargers.

Issue

(D.I.20) PIO - Support

Discussion

CSP PIO did not maintain a presence at the scene overnight. Doing so could have benefitted the media relations operation as specific questions generated overnight could have been researched and responded to in time for the morning broadcasts. The lack of an overnight representative created for a busier and more confusing morning as PIO attempted to research and answer questions from reporters in a timely manner.

PIO support staff, both on and off site, handled hundreds of telephone inquiries from around the world and prepared and distributed many press releases associated with the incident. Email correspondence and posting on the CSP website ensured that the media and the public were receiving current and accurate information.

Ensuring there were adequate portable restroom facilities at the staging area for the press would assure that the media would be able to remain at that site and not overwhelm the town.

Recommendations

(D.R.29) PIO commanders should ensure there is appropriate level of staffing to manage a large scale critical incident, including an overnight media Trooper, as well as a Trooper designated to manage social media.

(D.R.30) Anticipate the basic needs that will be required to maintain a prolonged media event, including adequate restroom facilities and other needs that might arise.

Issue

(D.I.21) PIO - Media Releases

Discussion

As the public demand continued for detailed information, small executive summaries were released by the States Attorney, allowing CSP PIO to confirm the details while ensuring that confidential information was not released. It was important that the families of the victims were aware of sensitive information prior to its public release.

Recommendation

(D.R.31) It is important to understand the impact the release of information has on victims and survivors. Where feasible, ensure victims and survivors are made aware of any major media releases in advance of public dissemination.

Issue

(D.I.22) Unauthorized disclosures

Discussion

PIO attempted to gather all first responder leaders to include Fire, EMS, and other local and federal agencies to ensure that no information would be publicly released from any other source. It proved difficult to limit some personnel from sharing incomplete and sometimes incorrect information publicly, especially when they saw an opportunity to appear on television. When leaders of the various organizations were briefed and asked to assist with channeling public releases of information through the PIO to ensure accuracy and consistency, the problem abated.

Recommendation

(D.R.32) Open and candid communication with leaders of the various agencies on scene is important to ensure information releases are being disseminated from official sources, in order to prevent dissemination of incorrect or sensitive information.

ANNEX E

ANNEX E - SUPPORT SERVICES

Introduction

The CSP and other responding agencies provided various support services to the survivors, decedents' family members, agency personnel, and to the community of Newtown. Many services and resources were in place prior to this incident to include the EAP and STOPS[8] programs. Others such as the Family Liaison Officer initiative was created as a result of this tragedy. Although this annex will not identify each agency support resource deployed, it will highlight some of the various observations and recommendations made by agency personnel who sought to comment accordingly.

Issue – Discussion - Recommendation

Issue

(E.I.1) Assistance to Troop Operations

Discussion

CSP commanders from across the state provided assistance to Troop A personnel and handled many duties and responsibilities to include logistical support, personnel management, normal troop operations, and EAP assistance. There was hesitation to leave the scene by many initial responders because of a sense of duty and responsibility.

In the days and weeks following the shooting, Troopers from Troop A had many additional responsibilites, including support of the ongoing investigation, a Presidential visit, funerals, Family Liason duties, and police coverage in the town of Newtown. Many of these Troopers who had been initial responders had experienced trauma, and likely would have benefited from varying periods of time before returning to regular duties.

Recommendations

(E.R.1) Establish a protocol that details standards for relief time for affected personnel.

(E.R.2) After an incident, identify Troopers negatively impacted and where appropriate, provide sufficient time before returning to patrol, allowing for debriefing and mental heath care as necessary.

Issue

(E.I.2) Keeping Troopers Informed

[8] State Troopers Offering Peer Support (STOPS) is a confidential, internal employee support program designed with the intent of trained troopers providing assistance to other troopers.

Discussion

Troopers on the ground often received information after it was made public. PIO should make every effort to inform Troopers and other responding personnel about critical facts and issues before they are publicly released.

Recommendation

(E.R.3) Advise affected personnel about relevant media releases in order to mitigate the dissemination of misinformation and rumors, either through the chain of command, the Everbridge system, or MDTs.

Issue

(E.I.3) Personnel Well-Being

Discussion

The impact of a mental health crisis lasts long after the critical event takes place. There should be an effective way to deal with the long term adverse effects to agency personnel with a tragedy of this magnitude.

To some degree, each detective assigned to this investigation was impacted emotionally. Some crime scene investigators reported there were varying degrees of distress among detectives during the investigation including the onset of post-traumatic stress.

Personnel that respond to a scene of this magnitude should be removed from the scene once it is deemed safe, the threat is neutralized, and there is no longer an immediate need for their services. A mandatory debriefing should be conducted within a reasonable amount of time for those personnel. Personnel should not be sent back to their respective Troops for patrol if they are not able.

It became mentally taxing for some investigators to drive by the shrines and mourners on a daily basis. At the end of the day, the drive to and from the crime scene was lined with reminders that affected each investigator on a personal level which made the task of completing the mission more challenging.

At the conclusion of the scene processing, the detectives assigned to the case had much more work to do, including additional processing of evidence, documentation of the incident, following up on leads, and communication with the families, resulting in investigators having to relive the experience on numerous occasions.

While well intentioned events such as invitations to meet with dignitaries, concerts and other events involved some personnel, work was quietly being done by those who were still operational. This dynamic reportedly caused a level of a discord and internal resentment among agency members.

Recommendations

(E.R.4) While still on scene, consider facilities that can accommodate the individual needs of investigative personnel to include a place to sleep, shower, and decompress, as well as a private route for detectives to come and go from the scene without the media cameras, shrines, or memorials for victims.

(E.R.5) A comprehensive debriefing should be conductedfor all affected personnel involved. If possible, it should be held as soon as possible after the event, and follow up debriefs should also be conducted. Assumptions should never be made regarding the emotional impact an event of this magnitude can have on a person.

(E.R.6) Consider mandatory counseling for Major Crime Detectives and other CSP personnel who deal with traumatic situations on a regular basis. Consider the emotional impact not only of those involved in the first response, but that of months of report writing, extensive viewing of graphic photographs, handling of evidence, and sharing lessons learned with other law enforcement agencies.

(E.R.7) Leaders should consider the impact on the family members of the detectives, and ensure that offers of available support are made to them.

Issue

(E.I.4) Support Detective in Crime Scene

Discussion

During the scene processing in SHES, detectives were not permitted to work alone, but each was assigned a partner. This allowed for the detectives to look out for one another and note any potential issues that might affect mental health and job related performance.

Recommendation

(E.R.8) Ensure the constant monitoring and support for personnel, especially during investigations of a potentially traumatic nature such as mass casualty investigations and those that involve young children.

Issue

(E.I.5) Crime Scene Mitigation Strategies

Discussion

There were numerous personal items that had to be identified and removed from the crime scene that became of important significance to the victims' family members. Due care and

consideration was given to these items by detectives processing the scene, and no item was dismissed as insignificant.

Recommendation

(E.R.9) Crime scene processors should always consider the significance and meaning of items within a crime scene not only for the evidentiary value it may hold, but for the personal significance it may hold for survivors or family members.

Issue

(E.I.6) Personnel Management

Discussion

At times, individual Troopers were assigned tasks that unnecessarily contributed to prolonged exposure to trauma, or were assigned to multiple such tasks without adequate time in between.

Recommendation

(E.R.10) Supervisors and commanders should consider the collateral mental health impact on the personnel they assign tasks associated with trauma for extended periods of time, or with multiple such assignmentsover time. Supervisors and commanders need to ensure they monitor the impact of these types of unique assignments on each individual employee and ensure clear communication with the Trooper. Supervisors and commanders should manage the assignment of agency personnel critically so that no individual is unduly burdened or affected.

Issue

(E.I.7) Dispatchers

Discussion

While Troopers are provided regular training during their careers in the form of active shooter training and experientials involving high stress situations, dispatchers do not typically receive this type of training. It was evident that involved dispatchers were emotionally involved in this incident and that they were also subject to possible mental health concerns.

Recommendations

(E.R.11) The agency should establish a program for developing dispatcher competency beyond mandatory yearly training agendas, including in-service training and professional development opportunities for dispatch personnel that incorporate mental well-being and the handling of traumatic incidents.

(E.R.12) A debriefing should be conducted for dispatchers soon after the event, and follow up debriefs should also be conducted. Assumptions should never be made regarding the emotional impact an event of this magnitude can have on a person.

Issue

(E.I.8) Unnecessary Exposure

Discussion

Unnecessary exposure to a graphic crime scene can result in avoidable psychological duress. Early on, proper direction was given by supervisors for personnel to stand guard at the classrooms most affected and direct other personnel away, however these posts were not maintained.

Recommendations

(E.R.13) All personnel should be made aware that it is in their own best interest to not needlessly go into these areas, and supervisors and commanders should make protecting personnel from unnecessaryharm a priority.

(E.R.14) This issue should be included in training on related topics, such as active shooter, supervisory, first responder and CP operations.

Issue

(E.I.9) P-Card Usage

Discussion

In the first days of the investigation, it became evident that additional supplies were needed to effectively outfit the Investigative Command Post and continue this investigation. The ability for investigators to go to local stores and buy these resources without delay was essential to the investigation.

Recommendation

(E.R.15) Continue P-Card usage and ensure supervisors remain aware of the freedom and rules pertaining to their use.

Issue

(E.I.10) Therapy/Counseling Services

Discussion

An underlying stigma remains in law enforcement associated with seeking treatment for the effects of post traumatic stress and other mental health issues. There are many confidential options for agency personnel that may be suffering from the effects of post traumatic stress disorder (PTSD), and personnel who have taken advantage of some of those available options have greatly benefitted. EAP services are an appropriate way to learn about the available options and the process for accessing them.

Recommendation

(E.R.16) Continue to use the EAP services to connect personnel with the mental health services that they need.

(E.R.17) Agency leaders should continue to incorporate the services of the mental health community in order to establish policies and procedures for appropriate treatment of agency personnel.

Issue

(E.I.11) Family Folders

Discussion

Special consideration was taken to support the families of the victims during this investigation. The agency conducted group and private meetings with the families early on, and continued to meet throughout the investigation. The agency also tracked information relayed to each family, in addition to the particular family's preferences regarding the dissemination of information.

In light of this, major crime detectives designed Family Folders with checklists and Family Support Forms to track this information. These folders kept this information in an orderly manner so that specific and proper support could be provided to the families over a long period of time.

Recommendations

(E.R.18) Continue to develop and improve the Family Folders and accompanying forms, and determine whether they can be incorporated into the NexGen reporting system.

Issue

(E.I.12) Meetings with the victims' families

Discussion

Private meetings were offered to the decedents' families by Major Crime detectives and were fulfilled at the families' requests, providing the same basic information about the incident that

was disclosed in the group family meetings as well as answering any questions they could regarding their family member. Families were also asked if they were okay with specific information about their family member being released to the other families and/or the media. These meetings seemed to be well received. Details regarding the specific information communicated, other information they wanted to know, and when they were comfortable knowing it was included in the family folders for reference. They were able to identify who they wanted to attend meetings (with them or on their behalf), including relatives, mental health providers, Family Liaison Officers, and clergy.

WDMC also held two group meetings for the familes of decedents and direct survivors during which basic facts were conveyed to dispell erroneous accounts that had been reported and families were given the opportunity to ask questions and raise concerns. Mental health professionals were on hand to provide the families with information and support, and Family Support Forms were handed out to collect information about each family and determine how best to support them in the future.

Recommendations

(E.R.19) Establish communication with families as soon as possible and continue an open dialogue through Family Liaison Officers, mental health practitioners, and the investigators.

(E.R.20) Law enforcement must not assume what is best for the families of victims. They should consult with experienced mental health professionals and ask the families which support(s) will work best for them.

(E.R.21) This support, meeting, and communication process with the families should be analyzed, improved and formalized with input from Major Crime personnel, Family Liaison Officers, mental health professionals and families, if available.

Issue

(E.I.13) Death Notifications

Discussion

Death notifications have typically been a duty of a patrol supervisor or Trooper, however the only formal training provided on the responsibility is at the recruit level. Troopers/Officers did these notifications under extremely challenging conditions, and although all were handled professionally and with compassion, some mistakes were made. In one instance, the Trooper did not know the correct relationship between the decedent and the family member he was notifying.

Death notifications are not only a critical time for the family members, but for police personnel as well. This is often the beginning of the communication process between police and the family and it is critical that it is done properly. These notification should be done

with the utmost compassion, and should be done as soon as possible to avoid undue stress and burden to the family.

Recommendations

(E.R.22) Distribute a Training Bulletin on this issue. Supervisors should conduct internal training within their units, to include "shadowing" of experienced Troopers by inexperienced ones when notifications are conducted.

(E.R.23) Design a check list of things to consider when assigned to do a death notification. Include in in-service training periodically.

Issue

(E.I.14) Family Liaison Program

Discussion

Family Liaison Officers (FLOs) were assigned to each decedent's family soon after the incident, and early assignment of these Troopers was critically important to the overall success of coordinating resources to victim family members. The FLOs performed many duties, including some of the official death notifications, communicating important information to and from the families, providing transportation and security for the families, providing comfort and monitoring the families' well-being, assisting in property returns, attending group and family meetings, assisting with shielding victim families from unwanted media attention, screening unexpected mail deliveries to victims’ families and other important services. CSP commanders empowered FLOs to make decisions with respect to the needs of their assigned family.

FLOs reported directly to the Major or Captain assigned at the CP in order to minimize miscommunication. The Major and Captain had daily interaction with each FLO to ensure their needs were met and to gauge their overall well-being.

Feedback regarding the program, from families, friends, clergy and even funeral home directors was positive. It was reported that the use of the program made it easy for detectives investigating the incident to communicate with the families during their time of grieving without having to disturb them unnecessarily. In June 2015, a meeting with a group of victim family members was conducted and there was overwhelming support for the program, and all family members present indicated they have continued contact with their FLO.

Selection of individuals to serve as FLOs is important. Not all Troopers are qualified, prepared or interested in being a FLO, and because this program had never been implemented by CSP, FLOs did not receive a lot of detail regarding what their assignment would entail and what the proper parameters were for family requests. Due in part to the lack of clarity, some requests were made of FLOs that went beyond what could be provided.

Geographic location is an important consideration as well. As the FLO duties often required working long hours for many days, living across the state from the victim families unnecessarily caused the added burden of having short turnaround times (rest/down time) before having to report to work again.

Another issue identified was the assignment of Troopers who had been first responders into the scene as FLOs. The emotional adjustment from direct action to FLO caused understandable concern for some personnel.

Also noted was that in some circumstances, the home Troops where the FLOs were assigned received insufficient notice and explanation of the FLO assignment, causing scheduling difficulties at the home Troop in the absence of the FLO.

Recommendations

(E.R.24) Formally establish a CSP Family Liaison Program consisting of adequately trained and screened volunteer FLOs dispersed throughout the state.

(E.R.25) Training for FLOs should include but not be limited to the role and responsibilities of an FLO, conducting death notifications, the assets and resources available for handling traumatic incidents, and coping skills and emotional support training.

(E.R.26) Whenever possible, avoid assigning first responders as FLOs.

(E.R.27) Ensure that FLOs have direct access to decision makers and are provided the necessary resources to ensure the impacted families receive the appropriate services in a timely manner.

Issue

(E.I.15) AAR Timeline

Discussion

The agency, its law enforcement partners, and the public at large deserve to learn from their experiences. The CSP has a responsibility to share their lessons learned within their own organization as well as their partners. As a matter of transparency and accountability, they also have a responsibility to the public they serve.

The agency utilized the IDROP[9] as one of the tools to solicit feedback, and posted a notification on the intranet site in an attempt to reach as many members as possible. Some unit supervisors and commanders required their personnel to provide feedback, but others did

[9] IDROP is the acronym for Issue-Discussion- Recommendation-Obstacle-Proponent. Refer to Appendix A for the IDROP form.

not. Some personnel indicated they were aware of the AAR process but felt reluctant to contribute. Group and personal interviews, and consultations were conducted to further contribute to this report.

The AAR process requires a level of commitment by all agency personnel to seek a constant state of personal and organizational improvement. Agency leaders should encourage their personnel to make observations about their individual and group performance and reflect on their experiences. They should strive to create a work environment that taps into the individual and group talents to identify best practice or areas for improvement. Fostering a work environment that encourages creative and innovating thinking requires high levels of commitment.

Recommendations

(E.R.28) Consider the utilization of an outside entity to complete the AAR if funds are available, and ensure the appropriate agency resources and support are allocated to the completion of a thorough and timely AAR.

(E.R.29) Consider completing and releasing future AARs in phases to allow for rapid dissemination of lessons learned in tactics and response without sacrificing the integrity of the investigation, and later updates that can address longer term, investigative and prosecutorial (if applicable) lessons learned.

(E.R.30) All agency personnel should be committed to the process of the AAR. Supervisory and command level personnel should encourage active participation by their personnel.

(E.R.31) The agency should continue to make strides in fostering trust and improve the overall cultural climate to ensure that members are not fearful of reprisal for offering constructive and professional criticism.

(E.R.32) Conduct training for the supervisory and command levels on how to properly conduct formal and informal AARs.

(E.R.33) Make AARs available to all agency personnel for review.

(E.R.34) Senior executive leaders should hold Troop and Unit commanders accountable for encouraging creative and innovative thinking as well as fostering transformational leadership practices.

(E.R.35) Appoint a steering committee or designee to follow up on AAR recommendations. Specific recommendations should be identified and improvement initiatives implemented.

(E.R.36) Consider revisions to CSP A&O Manual regarding the formatting and authoring of all AARs.

ANNEX F

ANNEX F – SURVIVORS' AND VICTIMS' FAMILIES

Introduction

The purpose of this AAR is to convey the many lessons learned from varying perspectives of agency personnel who responded to this incident. Although AARs are generally intended to glean lessons learned and identify best practices, it also provided a unique viewing lens into the organization through the internal perspective of the agency's members. In an effort to capture a more complete perspective, it is the intent of this report to include unique viewpoints by solicited feedback from family members of the victims. Great care and consideration was taken to ensure affected families were not placed into any further discomfort or an uncomfortable position or that providing the solicited feedback would cause further harm.

Each family member and survivor was provided an opportunity to respond to specific and general questions regarding some of the services provided to them by the CSP throughout the investigation of this incident. They were asked to be as critical and detailed as possible in identifying particular actions about what was done well and what could be improved. Personal and group interviews were also conducted with families and the information compiled has been reviewed and edited in an effort to capture the overall themes from each of the survivor and victim family members while respecting their privacy. All families were provided assurances that their comments would remain anonymous and they were asked to share only that information they were comfortable making public in this review.

Issue – Discussion - Recommendation

Issue

(F.I.1) Initial interaction with law enforcement

Discussion

The initial interaction with law enforcement personnel for many of the families was at the incident CP. The scene was described as very chaotic and confusing. Some family members indicated the police did not appear to be in control in part because of the large groups of children and parents reuniting. It also appeared as though they were unsure how to manage the chaos. Family members understood the situation the police were put in and indicated it would have been very difficult to pre-plan in order to manage.

There was an overall sense of frustration, and at times anger, because of the amount of time it took for the families to receive the final word about the victims. Some felt it was unnecessary and "tortuous" to have to wait for so long. During the delay, families were told that police were checking area hospitals and other locations to ensure accurate accountability. Other announcements made by police personnel were seen as unnecessary. As the delays

prolonged, information began circulating among family members about the large number of victims though the police did not provide any details even after being pressed to do so. Some respondents reported that it seemed as though the world knew what was going on and they were the last to find out.

Prior to sending family members home, FLOs were assigned in a support role to the families for the purpose of providing information and assisting in any needs they may have. Some family members reported they did not recall having any support provided when they went home from the firehouse. They felt as though they were simply advised to go home and would be contacted later without having final confirmation.

Recommendations

(F.R.1) Emergency personnel should be very mindful and sensitive to the implications of their initial interactions with survivors and exercise the discipline to maintain composure and compassion even in the most difficult of circumstances.

(F.R.2) Agency leaders must consider all the legitimate reasons for prolonging any delay in death notification with the highest consideration given to the family of deceased. If the victim of a mass casualty incident has been positively identified, law enforcement should consider making notification to the individual family member as quickly as possible rather than waiting for positive identification on all the victims at the same time.

(F.R.3) Ensure that each family member is provided as much accurate information regarding their loved one as soon as possible. Provide details on the investigative steps needed to properly process the scene and prepare the return of the deceased to the family. Provide them a personal point of contact.

Issue

(F.I.2) Death notification

Discussion

Some family respondents considered the firehouse location their official notification of the loss of their loved one. It was an extremely difficult and confusing time that was worsened by the wait. Some families do not recall an explanation from officials as to why they were not able to be with their loved one leaving unanswered questions while they were sent home.

The manner in which the families were sent home and then being notified later that night with the official confirmation of death was very difficult for some families to manage. Others indicated they understood how difficult it was for the troopers who came to their homes to make the official notification later in the evening.

Some respondents indicated that the use of clergy or other inexperienced counselors was not helpful although well intentioned.

Some family members regretted not being afforded the opportunity to be with their loved one prior to being sent home for the evening. Although the State Police had the best of intentions to protect the families because of the nature of the injuries, some family members reported that as parents, they should be able to make that decision. Other family respondents recalled they were sent home without a full understanding of what the process was going to be.

Recommendation

(F.R.4) Death notifications should be made by those best qualified to make it. Consideration should be given as to the time and manner of notification to minimize the impact. Conduct training for those who are likely to make such notifications as representatives of the agency.

(F.R.5) If feasible, attempt to provide an opportunity for the family members to have a private moment with their loved one. Do not send them home without an adequate explanation as to why they are not able to be with their loved one.

Issue

(F.I.3) Family Liaison Program

Discussion

The majority of family respondents noted that the family liaison officer was very helpful in meeting their needs. Many of the respondents indicated they developed a very positive and continuing relationship with the trooper that was assigned to them. Other families indicated they felt protected and were provided any reasonable request they had.

Recommendation

(F.R.6) The Family Liaison Program should be formalized and implemented by CSP.

Issue

(F.I.4) Media Relations and Information Releases

Discussion

The majority of the respondents conveyed a positive experience in the manner that CSP handled media relations. They were appreciative to have been informed prior to any major news releases. One respondent indicated that the CSP was careful and respectful in every communication and where mistakes were made they admitted and took responsibility for them.

It was difficult for some respondent families to deal with the constant pressure from media. Respondents indicated it was very helpful to their families to receive information from the CSP ahead of any news media releases so they could prepare for it. When mistakes were made or information about the case was disseminated without their knowledge, it caused further animosity for some respondents. Several respondents acknowledged that many of the information leaks came from sources that were out of the control of law enforcement.

Recommendation

(F.R.7) The agency should continue the practice of being mindful and respectful of the family members and how a media release may impact them.

Issue

(F.I.5) Group Family Meetings

Discussion

The group family meetings with investigators meeting allowed for a forum of candid discussion. Many questions were asked at the meetings that may otherwise have gone unaddressed. The content at the meetings was good however the manner of delivery could have been improved. Clearly established meeting guidelines allowed for participants to raise their hand as a signal to redirect the conversation. The information that was shared allowed for participants to understand the events better over time. As painful as the information was to hear, some respondents indicated it was helpful to know specifics detailing their family members death and that no questions were off limits.

Recommendations

(F.R.8) The agency should continue the practice of conducting group meetings with families in collaboration with mental health professionals and should establish appropriate guidelines and protocols.

(F.R.9) It is important to establish clear guidelines and solicit expectations from the participants for conducting meetings. Everyone should be mindful and respectful of the informational limits that can be tolerated by participants.

(F.R.10) Meeting facilitators and their presenters should be able to articulate the material in a courteous and professional manner. Proper preparation is paramount to success.

Issue

(F.I.6) Individual Meetings with Investigators

Discussion

The individual meetings with detectives proved to be very helpful and meaningful. The information conveyed in the individual meetings was delivered with care, respect and clarity which may have been missing in the group meetings because of the larger group dynamics.

Recommendations

(F.R.11) The agency should continue the practice of offering individual meetings with family members where appropriate.

(F.R.12) Appropriate levels of training should be conducted for those tasked with facilitating the individual meetings.

Issue

(F.I.7) Return of Property

Discussion

Each respondent was very grateful for the manner in which items of personal property were returned. Personal items were not simply bagged up and returned to the family members. It was apparent that thoughtful consideration was given by those who prepared the property for return.

Recommendation

(F.R.13) Investigators should be aware that no item seized in a crime scene should be deemed irrelevant. Items not considered essential for evidentiary value may be meaningful to surviving family members. Due care should be taken when returning personal property.

Issue

(F.I.8) School Walk Through

Discussion

Although the voluntary walk-through at the school was described by one respondent as a brutal experience, the manner, attention, and consideration shown by the detectives was exemplary. It was advantageous to include the Newtown police and other CSP troopers who were integral to the investigation. Having them available to give their personal accounts was incredibly helpful.

Investigators accompanying family members on the walk-through were respectful and mindful, and allowed family members time to be alone as needed. The manner in which the school was prepared for the walk-through demonstrated a high level of respect and consideration for the families.

Recommendation

(F.R.14) Allow the opportunity for family members to conduct a crime scene walk-through. Attempt to prepare the scene as best as possible. Have personnel available to answer any questions and provide appropriate details as questions arise. LE personnel escorting families on a crime scene walk-through should be mindful of the family member's needs and give them space to grieve as needed.

5. SUMMARY OF RECOMMENDATIONS

Pre-Incident Planning
Pre-incident planning is critical for active shooter or other mass casualty incidents. Police departments of all sizes must plan in advance for a large-scale critical incident response, including pre-planned mutual aid agreements and mutual assistance. Such planning should include identifying high risk target areas, building diagrams, appropriate staging areas and command post locations, establishing joint command with local police agencies, fire, and EMS, as well as compiling internal contact telephone numbers and testing communications procedures.

Command and Control
Staging Area: It is important that the Incident Scene Commander establish a staging area for emergency personnel as soon as practically possible, and all responding units, including those that self-dispatch, should report to the Incident Command Staging area for appropriate task assignments. Failure to do so can limit management control, increase risk, and severely hinder accountability.

Second Duty Commander: Designate an individual not involved in the incident to be responsible for the remainder of the troop patrol functions. Typically this function would fall back to the second in command (Troop Master Sergeant) when the senior commander is focused on a major incident. During this incident, the initial first responder team was comprised of the Commanding Officer and Executive Officer, as well as the duty supervisor. While Troop A was able to devote virtually all of its resources to this incident for the first several hours, this will not always be the case. It may be necessary in some instances to assign regular patrol operations to other troops within the district or adjoining districts.

Mutual Aid: All responding personnel and mutual aid that are not immediately needed should be staged at a nearby location. This will ensure their rapid deployment when their services are necessary, without flooding the incident scene prematurely. In accordance with NIMS/ICS guideline, assign a staging officer from the primary jurisdiction who may direct assignments. It is preferably to reach agreement before an emergency incident regarding span of control and the authority of outside agency supervisors to direct officers from other agencies.

Building Side Nomenclature: Standardize the designation of the front, rear, and sides of a building (e.g. “A” side, “B” side, etc.) and reinforce during training to ensure compliance and understanding among first responders. All involved agencies should operate under one system. Ensure all submitted reports reflect consistency in reporting.

Crime Scene Management
Reducing Stressors: Reduce noise and light stressors at incident scenes as soon as possible. Attempt to identify non-combatants and distinguish between potential threats and civilians. Sound and low light conditions add to confusion and make it difficult to make timely and

appropriate identifications. Additional stressors may hinder evacuations and search and rescue efforts.

Scene Security: Access to and from the crime scene should be strictly controlled from clearly established entrance and egress points, and reserved only for authorized personnel that have a legitimate and clearly defined reason for being on scene. No personnel should be allowed within a crime scene unless there is a legitimate law enforcement purpose. Agencies should consider video streaming or other means for crime scene viewing to assist in minimizing unnecessary crime scene traffic. Clearly established crime scene zones should be created and closely monitored with established ingress and egress points. Current policy and protocols should be reviewed to ensure that clear roles, responsibilities, and scope of authority are established for crime scene management.

Command Post (CP): CP operations were set up during the early stages of this incident at various locations, including a Crime Scene Processing CP at Sandy Hook Elementary School, a Criminal Investigation CP at the Emergency Operation Center, and an overall Incident CP at the Sandy Hook Fire House. As more emergency response personnel, family members, and media continued to converge on the scene, access to the Incident CP at the Fire House became difficult and it became apparent that it was an error to establish a CP at the school. At no time should any type of CP be set up inside an active crime scene, and commanders should be prepared to set up CP locations in a location that is outside of the crime scene and not widely accessible to the public.

Equipment

Body Armor: The Department currently provides body armor for each trooper; however, personnel are not required to wear the armor at all times. The department, in consultation with relevant labor unions, should consider revisiting the policies on body armor. Additionally, the armor provided to all troopers would not have protected responding personnel from the type of ammunition used at this scene. The Department should consider providing additional ballistic protection beyond the standard issued body armor for an extra layer of protection, especially to those who may be called to respond to an active shooter situation.

Medical Kits: Troopers assigned to patrol should have ready access to a medical kit. In the months following the Sandy Hook shooting incident, all CSP personnel were issued Individual First Aid Kits (IFAKs) and trained in their use. While the main purpose of the IFAK is to assist wounded officers, the skills and equipment can be used for civilian injuries as well.

Decontamination and Hydration: Many active crime scenes require decontamination and hydration stations and in this instance, several officers did not have access to clean water for washing and drinking. Consider procurement of a suitable “cleanup/hydration” station for use at major emergencies if not readily available from local emergency services.

Technology: Even with limited cell phone service, unit and district commanders should be able to communicate through the use of a smart phone or tablet. It should be noted that the agency has begun the process of updating phone technology and should consider issuing tablets with Wi-

Fi hot spot capabilities. The Agency should also review the technology capabilities for detectives within the Major Crime Units and update equipment and software as needed.

Major Crime: Each district Major Crime Unit should establish and maintain the equipment and resources necessary to respond to a mass casualty event within their respective geographic area of responsibility. Additionally, in accordance with available resources, the units should also have a secondary crime scene processing van and plan for its utilization.

Mobile Command Vehicle: The CSP was fortunate to have the use of various locations to use as CP locations. However, the Agency does not currently have an adequate mobile command vehicle with multi-functionality designed to handle an incident of this magnitude. Consideration should be given to acquiring a mobile command vehicle.

Training

Active Shooter: In response to the Hartford Distributor's active shooter incident in Manchester, CT in 2010, the department implemented mandatory training specific to active shooter incidents for all personnel during in-service. Additionally, all CSP personnel are given active shooter training at the recruit level. Numerous CSP first responders to Newtown indicated that the previous training they received provided an increased level of confidence. Future training would be beneficial to personnel, and should encompass additional response dynamics to include evacuation protocols, treatment of the injured, establishing perimeter zones, incident command and scene management, and setting up initial scene security. Active shooter training should include incorporating "stressors" to inoculate troopers to sensory overload. Troopers should also be mindful of the potential for "blue on blue" encounters and ensure muzzle discipline at all times. All levels of command should participate in integrated training exercises in mass casualty events to include the effective management of personnel, resources, technology, and command post operations.

Medical: The department has established a continuous EMS training schedule, and has also offered advanced training workshops in Tactical Combat Casualty Care (TCCC).

Emergency Vehicle Operation: It is critical for responding personnel to arrive to any incident safely. Despite the large law enforcement response to Sandy Hook Elementary School, there were no department accidents. All police departments should ensure their personnel are trained in emergency vehicle operation at the recruit level and on a regular basis thereafter.

Integrated Tactical Response: The FBI and the CSP responded in an integrated, tactical manner, which was influenced by prior training and pre-established professional working relationships. Local, state, and federal tactical teams should train together on joint problem solving scenarios to ensure success during future integrated operations.

Incident Command System and Unified Command: The CSP established its command presence within minutes of the incident. Other supporting agencies, with few exceptions, operated seamlessly and collaboratively within the existing operational framework. Organizations and individuals unfamiliar with the ICS and Unified Command concepts should train accordingly.

Communications

Radio Communications: Continuous radio updates were critical for personnel responding to Newtown. If an outside agency is provided a radio, ensure team leaders are advised accordingly. Use plain talk when communicating between agencies and attempt to increase effective communication between agencies.

Clearly Defined Roles and Responsibilities: Clearly defined roles and responsibilities should be established to limit miscommunication and potential for future errors. Protocols should be put in place in order to voice concerns upward through the chain of command without fear of reprisal.

Internal Agency Communication: The Agency kept the public informed through the Public Information Office and kept the families informed with informational meetings. The Agency should improve communications within the CSP, particularly with those who were involved directly as first responders.

Self-Dispatching

Organizations, response units, and individuals proceeding on their own initiative directly to an incident site, without the knowledge and permission of the host jurisdiction and the Incident Commander complicate the exercise of command, increase the risks faced by responders, and challenge accountability. Mass casualty and active shooter response plans should include pre-selected and well-marked staging areas and a plan for handling self-dispatched personnel.

Dispatch instructions should be clear. Law enforcement agencies should be familiar with deployment plans and quickly establish incident site access controls. When identified, self-dispatched resources should be immediately released from the scene, unless incorporated into the Incident Commander's response plan.

Mental Health and Wellness

Ensuring access to care: The magnitude of this incident, especially given the age and number of victims, certainly had an impact on all responding personnel. The agency must ensure that responding personnel are receiving proper mental health services prior to an event and long after. Employee Assistance Programs are a critical component to a long term mental wellness process. Additionally, the CSP currently has a confidential employee assistance and peer support (STOPS) program. They also have established policy and procedures outlined in the A&O Manual which addresses dealing with potentially distressed employees through the Personnel Early Awareness and Intervention System. Commanders should be prepared to deal with the short and long term effects on personnel who respond to mass casualty incidents. Investigators, responders, and the families of those who were involved in this investigation should be provided EAP and other resources in order to deal with any potential adverse effects.

Limiting impact of trauma: Commanders should strive to minimize the potential adverse effects of crime scene exposure and all law enforcement personnel should be mindful to avoid unnecessary exposure to trauma. Crime scene access should be given only to individuals with a legitimate law enforcement need, regardless of rank.

Long term care: Mental health experts maintain that effects of post-traumatic stress may not manifest until years after the event. CSP leaders should continuously support their personnel's health and well-being in the short and long term.

Law Enforcement Collaboration

Due to the magnitude of this incident, there was an overwhelming law enforcement response on the local, state, and federal level. All available resources were made available to investigative personnel. Commanders established effective communication between the States's Attorney as well as other law enforcement partners. It is important to have effective working relationships and personal points of contact in place before the need for the contact arises. Establishing and maintaining law enforcement partnerships is critical to overall mission success.

Reporting

The agency utilizes an in-house system to document investigations. There were some issues regarding late reports and the submission of reports that had errors despite having been approved by a supervisor. The agency should emphasize the importance of report writing competencies and strive to take immediate corrective steps to prevent inaccurate, untimely, and poorly written reports. The Agency currently has policies and procedures outlined in the A&O Manual that address reporting requirements and these policies and procedures should be followed and enforced. Additionally, at the time of the incident certain units did not fully utilize the electronic reporting system which made it difficult for the assigned investigators to access and review reports; however, since that time the system has been implemented in all units agency-wide and now all reports are completed through the same system.

Support Services

Death Notifications: Accurate and timely death notification to victims' families should be one of the highest priorities. Delays in notification were a great source of frustration for agency personnel at the firehouse CP location and added confusion, frustration, and stress for the family members. Policy and procedures should be clearly established and enforced to ensure accurate and timely death notifications are made to family members. If feasible, consider honoring family requests to view the victim.

Family Liaison Program: The family liaison program was an important victim assistance program that provided support and communication to the victims' families. The agency should continue to develop this program and include it in operational response protocols for mass casualty incidents, along with other victim services as deemed appropriate.

Family and Individual Meetings: In addition to assigning liaison officers to each impacted family, CSP made every attempt to keep the families informed of the case investigation through individual and group meetings. The purpose of the meetings was to provide accurate and timely information and to dispel circulating rumors. The meetings were private and helped prepare the families for upcoming media releases. The practice of conducting individual and group family meetings should be sustained and included in operational protocols. Ensure that meeting guidelines are set and adhered to ahead of time. LE should be prepared to answer questions and provide assistance to individuals who are grieving. Victim assistance should be done in consultation with mental health and grief counseling experts.

Scene Walk-Throughs: Family members were allowed to visit the school once the crime scene was cleared. In the future, this could include victim advocates, mental health professionals, and LE personnel to answer questions and assist as appropriate.

Public Information

PIO released accurate and timely information to the numerous media outlets. PIO was able to convey information without compromising the investigation, and at the same time honoring the privacy of the impacted families. PIO should further consider preparing operational plans for similar mass media events and anticipate the various equipment and personnel needs that may arise.

6. CLOSING

In summary, the response to the December 14, 2012 attack at Sandy Hook Elementary School was handled effectively. Had it not been for the heroic actions of the teachers, school staff and the response force, the number of victims could have been higher.

Although the response to the attack at Sandy Hook Elementary School is commendable, this AAR conveys many recommendations and lessons learned for improving response and rescue capabilities to better meet the challenges of this type of emerging threat. This important information should be shared with other jurisdictions around the country so the nation benefits from Connecticut State Police's experience, both in preparing for the police response to mass casualty events and the subsequent investigative and support service challenges they pose.